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ABSTRACT

As states respond to major welfare legislation in providing assistance and other interventions to help adults on welfare become ready to work, the challenge of helping these adults in their parenting skills and in promoting resilience in their children has often been ignored. This issue brief addresses the challenge of promoting resilience in children whose parents are experiencing domestic violence, substance abuse, and serious mental health issues, including depression. Section 1 of the brief highlights the dimensions of the challenge, focusing on policy issues, family characteristics, and challenges for service providers. Section 2 highlights services strategies to: (1) promote resilience, social competence, and school readiness in the children of the most vulnerable parents; (2) repair or prevent damaged parent-child relationships among young children whose parents face severe risks; and (3) ensure the safety of the children while helping parents meet the work-related goals of the Personal Responsibility and Work Opportunity Reconciliation Act. Section 3 suggests steps that policymakers, service providers, private funders, and advocates might take to improve outcomes for and investments in young children in high-risk families. The brief's three appendices describe the "Starting Early Starting Smart" sites, list helpful national organizations and agencies, and provide contact information for several programs. (Contains 63 endnotes.) (KB)

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Children and Welfare Reform

Issue Brief 8

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Promoting Resilience:

Helping Young Children and Parents Affected by Substance Abuse, Domestic Violence, and Depression in the Context of Welfare Reform

Jane Knitzer

PS028412

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NATIONAL CENTER FOR CHILDREN IN POVERTY

National Center for Children in Poverty

1989–1999: A Decade of Work for Low-Income Young Children and Families

The National Center for Children in Poverty (NCCP) was established in 1989 at the School of Public Health, Columbia University, with core support from the Ford Foundation and the Carnegie Corporation of New York. The Center's mission is to identify and promote strategies that reduce the number of young children living in poverty in the United States and that improve the life chances of the millions of children under age six who are growing up poor.

The Center:

- Alerts the public to demographic statistics about child poverty and to scientific research on the serious impact of poverty on young children, their families, and their communities.
- Designs and conducts field-based studies to identify programs, policies, and practices that work best for young children and their families living in poverty.
- Disseminates information about early childhood care and education, child health, and family and community support to government officials, private organizations, and child advocates, and provides a state and local perspective on relevant national issues.
- Brings together public and private groups to assess the efficacy of current and potential strategies to lower the young child poverty rate and to improve the well-being of young children in poverty, their families, and their communities.
- Challenges policymakers and opinion leaders to help ameliorate the adverse consequences of poverty on young children.

Series Introduction

When the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) was enacted, the National Center for Children in Poverty (NCCP) recognized that the law and its subsequent amendments would have a major impact on the health and development of young children living in poverty. In response, the Center established the Children and Welfare Leadership Project to promote the implementation of welfare reform in a manner that leads to better outcomes for children and families.

The Children and Welfare Leadership Project is based on a growing body of research that suggests that successful policies for families must take into account the needs of children when addressing the needs of parents and the needs of parents when addressing the needs of children. The Project recognizes that the primary focus of welfare reform is to ensure that adults achieve economic self-sufficiency. But welfare reform also has the potential to help or hurt children in three major ways: (1) by changing family income; (2) by changing the level of parental stress and/or parenting styles; and (3) by changing children's access to or the quality of comprehensive family support and child-focused services.

Building on this framework, NCCP has developed a series of issue briefs that focus on ways states and communities can achieve the adult-focused goals of welfare reform *and* enhance the well-being of their young children. This issue brief, *Promoting Resiliency: Helping Young Children and Parents Affected by Substance Abuse, Domestic Violence, and Depression in the Context of Welfare Reform*, marks the eighth in the series. It addresses the needs of an especially vulnerable population of young children and families affected by welfare reform, those in which the adults, particularly mothers, either singly, or more often in combination, experience substance abuse, domestic violence, and serious mental health problems. These parental risk factors significantly increase the likelihood that their children will have developmental, behavioral, or school problems.

Support for the development of the issue brief has come from the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services. NCCP is especially grateful to Judith Katz-Leavy, for her encouragement throughout the process of developing the brief, and to the Annie E. Casey Foundation, which has generously supported NCCP's Children and Welfare Reform Project from its inception and which has provided supplemental funds to support the publication of this brief.

Much of what is reported here was first discussed at a meeting convened by NCCP in 1998 to bring together researchers, policymakers, federal and state officials, and advocates to address the challenge of helping families who have young children and who experience the most severe barriers to work. The Center is especially grateful to the participants at that meeting and to Dr. Suniya Luthar, Dr. Hiro Yoshikawa, Dr. Jim Rast, and Carole Oshinsky for reviewing earlier drafts. Their collective insights have helped us understand the complexity of the challenge the field faces as well as the opportunities that welfare reform holds for this very vulnerable population. As always, thanks are due to the staff at NCCP, who go above and beyond the call of duty in making these issue briefs a reality.

Jane Knitzer, Ed. D., is deputy director of NCCP and director for program and policy analysis.

This issue brief is dedicated, with love, to my daughters, Lizbeth and Susie. By example, they have inspired me to keep focused on the needs of the most vulnerable and taught me what it means to be courageous under stress.

Promoting Resilience: Helping Young Children and Parents Affected by Substance Abuse, Domestic Violence, and Depression in the Context of Welfare Reform by Jane Knitzer

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"The families that we are talking about are so complex. It is low literacy, it is lack of education, it is substance abuse, mental health, domestic violence. We have to be mindful of this and not just look at substance abuse or mental health or low literacy or domestic violence, because we are going to miss the boat."

A participant at the NCCP meeting, Promoting Child and Family Resilience in the Context of Welfare Reform, Washington, D.C., October 1998

Since the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), the major welfare reform legislation of the late 20th century, there have been dramatic reductions in welfare caseloads.[1] Attention is now turning to how to meet the needs of those adults who are currently unable to enter the work force successfully and are thus likely to face time limits and sanctions.[2] This issue brief focuses on a subset of this population, those who experience, either singly or in combination, domestic violence, substance abuse (including alcohol, drugs, and other substances),[3] and serious mental health issues, including depression, *and* who are parents of young children.[4]

For these families, both common sense and research suggest that treatment and other interventions to help the adults become ready to work are crucial. But so, too, are interventions to address parenting issues and to promote resilience in their children—the ability to adapt and thrive even in the face of especially difficult circumstances.[5] States are beginning to address the first challenge. This issue brief addresses the second, often ignored, challenge. It is organized in three sections. The first section highlights the dimensions of the challenge. The second section highlights service strategies to: (1) promote resilience, social competence, and school readiness in the children of the most vulnerable parents; (2) repair (or prevent) damaged parent-child relationships among young children whose parents face severe risks; and (3) ensure the safety of the children while helping parents meet the work-related goals of PRWORA. The third section suggests steps that policymakers, service providers, private funders, and advocates might take to improve outcomes for and investments in young children in high-risk families.

Setting the Context: The Dimensions of the Challenge

The Policy Challenge

For adults, the emphasis in the 1996 welfare legislation is almost entirely on work; this is particularly true of the law's Title 1 section—the Temporary Assistance to Needy Families (TANF) block grant to states.[6] For hard-to-serve adults, the law identifies substance abuse and domestic violence as barriers to work, but treats each differently.[7] Although mental health issues are not specifically mentioned, states have the option of exempting 20 percent of their caseload from the work requirements.[8] Within this framework, states have considerable flexibility in how they structure responses to the most high-risk adults.

For children, although PRWORA requires efforts to see that all families have access to child care so parents can work, the law does not explicitly set forth a goal of promoting their developmental, emotional, and social well-being, even for those children who are most vulnerable for poor outcomes. Other federal legislation, however, identifies a national goal that is particularly relevant to these young children—Goal I of the Educate America Act—that "every child shall enter school ready to learn."[9] The marriage of these two national goals—one to see that parents work, the other to see that children enter school ready to learn—offers a framework for linking welfare implementation with school readiness agendas and other early childhood initiatives at the state and community levels to benefit the most vulnerable adults and their young children.

The Family Challenge

Parents make up 30 percent of all welfare recipients, with children accounting for the rest; over one-third of the children are under age six.[10] There are no national data, however, on the number of parents with young children affected by both TANF and the kinds of risk factors identified here.

Adult-focused prevalence studies, which generally address one risk factor at a time, consistently reveal that the risk factors highlighted here are disproportionately

What Research Shows About Vulnerable Parents

- *Prevalence estimates of substance abuse among welfare recipients range from 16–37 percent.*[11]
- *Studies of domestic violence indicate significantly elevated rates among the welfare population.* While a national survey found that 1.5 percent of women reported having been physically abused in the preceding 12 months, a methodologically careful state study of AFDC recipients found that 20 percent had experienced domestic violence in a 12 month period.[12]
- *Low-income parents are more likely to have higher rates of mental health problems.* A recent study of 13 states found that 28 percent of children in low-income families lived with a parent with symptoms suggestive of poor mental health, compared with 17 percent of all children.[13]
- *Maternal depression, which is particularly harmful to young children,*[14] *is disproportionately prevalent among low-income mothers.* One study using a sample of welfare recipients with young children found that 42 percent of the parents had clinical levels of depression, at rates two to four times as high as that in the general population.[15]

What Research Shows About Young Children in Vulnerable Families

- As infants and toddlers, the babies may show signs of attachment disorders, being unable to relate to their parents or other caregivers.[17]
- The impact on young children lasts. Recent research indicates that babies whose mothers are depressed do worse on school readiness and behavioral indicators at age three.[18] As preschoolers, they may "act out" in early childhood programs, and sometimes be ejected from them.[19] (These behaviors are often the precursors of conduct disorders).
- Many of the young children display developmental delays and may show symptoms of post-traumatic stress disorder.[20]
- Often the children and their parents are in poor health.[21]
- Early childhood staff who work with these children in home visiting, child care, Early Head Start and Head Start settings typically report that the children are sad, anxious, aggressive, and impulsive, either singly or in combination.[22]
- The children are more likely to develop behavior patterns similar to those of their parents. Some research indicates that as adolescents, they are especially vulnerable to alcohol, tobacco, drugs, and other substance abuse and other high-risk behaviors.[23]

present among low-income families, and particularly women receiving welfare, at least under the predecessor program to TANF—Aid to Families with Dependent Children (AFDC). (See box summarizing key findings on vulnerable parents.)

Still other studies confirm what practitioners know—risk factors do not come neatly packaged. These women's lives are characterized by histories of physical or sexual abuse, serious mental health issues, and chronic trauma as well as substance abuse, coexisting with learning disabilities, poor work histories, and sometimes homelessness.[16]

Some young children in families with adults affected by these risk factors are resilient and will do fine. But in general, research paints a sobering picture of the children's well-being. All poor children are at risk of not achieving expected developmental, behavioral, social, and academic competencies, although child and family-focused interventions in early childhood can improve the odds.[24] Research also indicates that being poor in the earliest years has more harmful consequences than does experiencing poverty at later ages.[25] But for children in what has been labeled "double jeopardy"[26]—that is, being poor and facing the special challenges identified here—the risk of poor outcomes multiplies.[27] (See box summarizing key findings of research on vulnerable children.)

The bottom line is that many of these young children have been traumatized in one way or another, and without intensive interventions, the prognosis for them as they enter school is, too often, not good. This, coupled with emerging evidence about the importance of early brain development, has turned the spotlight on the lasting impacts of early relationships.[28] It has also underscored the urgent need to identify, develop, and test intervention strategies that complement work and treatment strategies targeted to parents.

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The Service Challenge

The interweaving of risk factors in the lives of women who are affected by substance abuse, serious mental health issues, or domestic violence and their children poses great challenges to service providers. Adult-focused services, like policies and research, are typically organized categorically and address one rather than multiple risk factors. Yet family needs cut across many issues and service systems. The adults need basic supports (help with housing, work, and life skills), they need treatment in a safe environment, and often they need to learn to parent in new ways.

Programs targeted to young children and families (such as home visiting, child care, Head Start, prekindergarten, and Early Head Start programs) are not usually staffed or organized to provide the kinds of services that the most stressed children or their families need. Staff members report that they recognize young children and families at special risk, but that they are at a loss about how to wrap an adequate system of supports around these families.[29] (See box describing how early childhood practitioners can identify the danger signs.) They lack training and have no guidance from consultants. They either have no relationships with community agencies dealing with adults with substance abuse, domestic violence, or mental health problems or the treatment agencies in their communities simply do not serve young children.[30] Children and families served in the context of Head Start and Early Head Start have somewhat of an advantage; these programs have performance standards that require not only comprehensive family and child services, but explicit attention to family risks and the emotional well-being of the families. Yet here, too, research suggests that staff struggle to help these families.[31]

The message is clear. Providing effective services to parents affected by substance abuse, domestic violence, and serious mental health problems and their young children is an urgent but complex undertaking. These families' needs cut across categorical programs, disciplines, and roles. They require the development of new formal partnerships, informal relationships, and a commitment to connecting parts of the service system that are not typically aligned. (See box on page 6 outlining the service challenge.)

Providing effective services to parents affected by substance abuse, domestic violence, and serious mental health problems and their young children is an urgent but complex undertaking. These families' needs cut across categorical programs, disciplines, and roles. They require the development of new formal partnerships, informal relationships, and a commitment to connecting parts of the service system that are not typically aligned.

Danger Signs: How Early Childhood Practitioners Can Identify Vulnerable Parents

Parents at high risk for substance abuse, serious mental health problems, and domestic violence exhibit the following traits:

- Inability to make and keep appointments and follow through on other key responsibilities, such as preparing paperwork to prevent welfare checks from being cut off.
- Employment history that includes repeated job loss after short intervals, inability to accept supervision, or difficulty getting along with employers.
- Lack of basic literacy skills, even if opportunities have been made available.
- Chronic oppositional problems, including being asked to leave school or having difficulty with authority figures.
- Unstable housing patterns, including being kicked out of apartments or drifting from one living arrangement to another.
- Severe personality disorders, including being addicted to crises as well as to substances or unable to form stable relationships even with emotional support.
- Chronic impulsive behavior; time-sequencing problems; inability to attend (adult ADHD); or magical thinking. (For example, if they hear about a job or an apartment they speak as if it's theirs whether or not they even made any attempt to contact that employer or landlord.)
- Signs of fetal alcohol effects or other neurological damage.

Source: Susan Harding, Director, Addison County, Vermont, Parent-Child Center, based on input from her staff.

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Overview of the Service Challenge

Families of vulnerable young children exhibit multiple acute and/or chronic conditions that have been undiagnosed or misdiagnosed.

- The young children often have poor physical health, speech, language, and behavior problems, although most are not neurologically based.
- Relationships between the young child and caregiver are usually impaired, reflecting some degree of attachment disorder.
- Families struggle greatly to meet basic needs, especially for food, shelter, child care, and adequate income.
- Adults need *both* substance abuse treatment and behavioral health services.

Critical support services needed for young children include:

- Health care (e.g., immunizations, primary pediatric care, and identification and follow-up of special health needs).
- Screening for developmental delays and age-appropriate developmental services (e.g., behavioral interventions, speech and language services).
- Parent education activities (such as modeling healthier parent-child interaction and teaching parents age-appropriate child behavior and development).

Critical services needed for families include:

- Basic support services (e.g., child care subsidies, access to housing, food stamps, information about income credit programs).
- Specialized support services (e.g., substance abuse treatment, relapse prevention supports, behavioral health services, domestic violence assessment, prevention, or safety strategies).

Factors that promote program success include:

- Including families in multidisciplinary team meetings.
- Establishing close links between early care and education staff working with the child and those working with the family.
- Using a strength-based approach to assess families' needs and capabilities.
- Making it easy for clients to obtain the needed range of supports.
- Involving or creating informal support networks.
- Using parents in successful recovery as staff to help other parents.
- Building a focus on parenting into outpatient substance abuse treatment programs.

Sources: Jillson, I. A. (October 29, 1998). Women, children, and the social safety net: Why care is critical, special presentation to the Children and Welfare Reform Leadership Network meeting: Promoting Child and Family Resiliency in the Context of Welfare Reform, sponsored by the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services, Washington, D.C. and Jillson, I. A. (1998). *Draft report: SAMHSA's Integrated children and family initiative: Responding to an unmet need.* Washington, DC: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Responding to the Challenge: Service Strategies to Promote the Well-Being of Vulnerable Young Children and Families

This section highlights programs and strategies to: (1) promote resilience, social competence, and school readiness in the children of the most vulnerable parents; (2) repair (or prevent) damaged parent-child relationships among young children whose parents face severe risks; and (3) ensure the safety of the children while helping parents meet the work-related goals of welfare reform. The examples are drawn from research and best practice profiles undertaken by NCCP and others, supplemented with interviews. They illustrate how different systems can serve as entry points. For an overview of the strategies, see box on page 7. Contact information is given in Appendix C.

Early Childhood Services as an Entry Point

Major efforts are underway to increase the quality and availability of early care and education programs, including child care, Head Start, prekindergarten, and Early Head Start for infants and toddlers.[32] Three strategies using early childhood settings as the entry point to serve families affected by substance abuse, domestic violence and depression and other mental health problems are highlighted below.

STRATEGY: Integrate behavioral service teams into primary health care, child care, and Head Start settings.

Integrating intensive behavioral health services for children into early childhood programs and at the same time connecting the adults with the supports they need provides a potentially powerful approach to helping families with complex needs. It builds on the trust that many of these families feel toward health and early childhood settings, and it is consistent with the best principles of early intervention, which promote services in normal settings.

Starting Early Starting Smart. In 1997, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) joined with a private group, the Casey Family Program, to create Starting Early Start-

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Strategies to Promote Resilience in the Most Stressed Young Children and Families

Point of Entry—Early Childhood Services

- Integrate behavioral service teams into primary health care, child care, and Head Start settings.
- Build a statewide system of behavioral supports for young children and families.
- Increase the skills and competencies of early childhood staff to address multineed families.

Point of Entry—Substance Abuse, Mental Health, and Domestic Violence Services

- Integrate intensive early childhood and family-focused services in substance abuse and mental health settings.

Point of Entry—Welfare Agencies

- Connect children living with grandparents and relatives, but receiving welfare (the so-called "child-only" cases) with appropriate prevention, treatment, and support services.
- Address the needs of both custodial and noncustodial fathers affected by substance abuse, violence, and mental health issues, as well as mothers.
- Use welfare-related dollars to promote integrated behavioral and child development for the most stressed young children and families.
- Bring TANF, early childhood, substance abuse, mental health, and domestic violence staff together.

ing Smart (SESS), a public-private initiative. Together, with supplemental support from other federal agencies, they funded 12 grantees as part of a research and demonstration initiative to develop child-centered, family-focused, and community-based interventions in child care and child health settings. The aim was to support the healthy development of children up to age seven who are affected by alcohol or other substance abuse and serious mental health issues, and to prevent their entry or greater penetration into the child welfare system.

The SESS sites fall into three categories. The four programs based in primary health care settings link low-income, high-risk families to specialists, provide basic advocacy services, help families develop concrete strategies to ensure the safety of their children, and, in some instances, offer special therapeutic interventions. The six sites based in early childhood programs (five of them in Head Start settings) tend to be more child-focused,

"The central question is how to 'knit together' a wide range of systems and services on behalf of the most vulnerable parents, so that they can experience success in transitioning to work and in providing nurturing parenting, and their children can get the services they need."

A participant at the NCCP meeting, Promoting Child and Family Resilience in the Context of Welfare Reform, Washington, D.C., October 1998

addressing the needs of children whose problems are most severe as well as those manifesting high-risk behaviors, although some include staff development activities and parent involvement strategies.[33] The remaining two programs are designed to meet the needs of a Native American tribe and young children in foster care. (See Appendix A for more details about the sites). A national evaluation is currently under way.

STRATEGY: Build a statewide system of behavioral supports for young children and families.

Nurturing early relationships appears to be key to later emotional development, which in turn is related to success in school. As states pay more attention to school readiness, they have an important opportunity to promote the emotional development of the most vulnerable young children and families. At the same time, no one system has claimed lead responsibility for this group of children.

The Children's Upstream Project (CUPS). The state of Vermont has been making a deliberate, sustained, and multipronged effort to improve outcomes for young children for a number of years.[34] In response to a state report entitled *Prevention and Early Intervention: Necessary Next Steps*, Vermont is in the process of developing the first statewide early childhood mental health initiative. (Vermont teachers estimated that about 30 percent of its young children lacked the emotional and other skills needed to succeed in school.[35]) Funded with a Children's Mental Health Services grant, the aim is to develop an early childhood mental health system of care that includes prevention and treatment, and engages the early childhood community and multiple

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systems in planning and implementation. The name Children's Upstream Project, or CUPS, was chosen to emphasize the prevention focus of the initiative. It refers to the often told story of children being thrown into a river faster and faster with rescuers trying to rescue each of them as they come downstream, but no one going upstream to find out who (or what) is throwing them in.

CUPS builds on existing regional early childhood planning networks by promoting new partnerships that link the early childhood community with planners and providers from mental health, substance abuse, domestic violence, and child health agencies, as well as parents. Although the lead agency is the mental health agency, CUPS is supported by a state-level outreach team involving many agencies. According to its leaders, the effort has been challenging. Bringing together domestic violence, mental health, and substance abuse agencies involves exploring different organizational cultures and visions; adding a child development and family support perspective makes the task even more complex.

The dialogue is paying off in new services and connections. These include informal play groups with mental health consultants, flexible "wraparound" services to meet particular family needs, increased access to mental health consultants and clinical supervision for child care providers (made possible by using mental health dollars to provide substitute caregivers), and active development of parent-to-parent support groups. CUPS has seeded training for family workers, child care providers, mental health workers, and TANF workers. It has also arranged for mental health professionals to become the core providers if families being served by home visitors through Vermont's Healthy Babies program need more intensive services to meet complex needs. An evaluation is in process that deliberately links outcomes with the state's school readiness effort.

STRATEGY: Increase the skills and competencies of staff in early childhood programs to help multineed families.

Providing staff who work with young children with dependable, on-site access to behavioral expertise is a "value added" strategy. Helping staff cope more effectively with the most challenged children and families not only benefits those children and families directly, it also gives staff tools for all children that, in turn, can improve the quality of the overall program. Two consultation approaches being used in child care centers are highlighted here, followed by a description of a home visiting program that builds some of the needed support staff directly into the basic staffing pattern.

Day Care Plus. In Cleveland, a highly respected (and relatively rare) parent-driven early intervention program for the most challenged and challenging children and families, the Parent Intervention Centers of the Positive Education Program, has joined forces with the local child care resource and referral agency to develop a consultation and outreach program for local child care centers. The aim is to reduce child care staff turnover, lower the numbers of children at risk of being expelled, and help the staff improve the quality of the program.

Blended funding for the initiative comes from the local child care resource and referral agency, the county mental health board, and the Parent Intervention Centers. The model relies on a "train-the-trainer" approach, working intensively with a cohort of child care programs for a limited time period, with decreased but ongoing support after that. Family advocates are available to assist parents of children in the program. There is also a community-focused component. For example, recognizing the disconnect between the early childhood community and the behavioral services community, Day Care Plus hosted a meeting to build relationships between child care staff and staff at substance abuse and mental health treatment agencies. An evaluation is under way.

Project Relationship. Project Relationship was developed by the Los Angeles Unified School District, Division of Special Education Infant and Toddler Programs, with the support from the U.S. Department of Special Education.[36] Here, too, the aim is to enhance the competencies of those working directly with children and families through a process of inquiry, reflection, and respect that is outlined in a manual and accompanying video. The program is based on a structured problem-solving approach, "Going Around the Circle," which can be used as a guide to facilitate more open communication but is responsive to the particular issues, interpersonal dynamics, and culture of each child care

setting. The goal is to help staff better understand the behavioral cues of young children, promote special attachments between specific caregivers and young children, and facilitate dialogue among staff, children, and families about feelings, issues, and conflicts.

These efforts to build in consultation strategies to address the emotional needs of young children and families in the context of child care are still few and far between, but they are not unique.[37] San Francisco has dedicated a proportion of its $2 million Child Care Quality Enhancement Fund for mental health strategies that includes consultation in child care settings.[38] Westchester County is supporting a network of consultants for its Head Start programs, orchestrated by the Center for Preventive Psychiatry. These efforts are important. At the same time, they are largely limited to children in center-based care, not to the many children cared for in family child care homes or by neighbors and relatives.[39]

Support services targeted to parents with young children are also growing. These may be offered through family support centers, through home-based outreach programs, or through didactic or peer-centered parent education. As with center-based child care, staff in these parent-focused programs also report working with more and more vulnerable and challenging families, typically without help in doing so.[40]

California Safe and Healthy Families (Cal-SAHF). This home visiting program expects the families it serves will have multiple and complex needs related to substance abuse, domestic violence, and mental health issues, and designs its staffing plan around these needs.[41] Using as its model psychosocial rehabilitation methods, which provide a combination of support and concrete services to mentally ill adults, its aims are to reduce the need for child welfare interventions, decrease psychiatric and other medical costs, improve child health and developmental outcomes, promote positive parenting, and reduce dependence upon public assistance. Families receive individualized home visits supplemented by weekly groups for parents and children, help with child care and transportation, and other supports as needed. Multidisciplinary teams that include a licensed clinical social worker or registered nurse who acts as the team leader, home visitors, a child development specialist, a group coordinator, a child care aid, and, increasingly, CALWorks/TANF staff, work with 20 to 25 families at a time. The effort is currently being evaluated.[42]

Seven Cal-SAHF programs are now funded by a combination of federal (Child Abuse Prevention and Treatment Act) and state funds. (Consideration is being given to using TANF funds for the model.) In addition, Cal-SAHF and related approaches have evolved into a much larger statewide initiative (now in 17 counties) that incorporates treatment, home visiting, and intensive case management linked with family resource centers. Known as ABC (Answers Benefiting Children) the goals are to: achieve positive health and developmental outcomes for *all* family members, improve children's cognitive development and school readiness, prevent or reduce adverse outcomes for parents, and strengthen and support families and communities.

Substance Abuse, Mental Health, and Domestic Violence Services as the Entry Point

Traditionally, behavioral health systems, encompassing mental health or substance abuse agencies, have focused primarily on adults, without taking into account the reality that many of their clients are parents. Thus, they tend not to integrate parenting support strategies for the adults or child-focused strategies for their children.[43] The examples below are exceptions.

*STRATEGY: **Integrate intensive early childhood and family-focused services into substance abuse and mental health settings.***

Recognizing the lack of knowledge about how to integrate a focus on parenting and young children into substance abuse treatment and mental health settings, between 1995 and 1998, SAMHSA funded eight grants to existing substance abuse treatment or prevention and mental health programs to improve the children's current and future mental health and social development as well as general family functioning. The focus was on young children ages birth to seven years.[44] Project BEFORE, one of the mental health supplemental grantees, is highlighted below.

Project BEFORE (Bridging Empowers Families to Overcome Risks and Excel). Based in rural Kansas, Project BEFORE was targeted to young children under age six and their caregivers who either had, or was at risk of having a substance abuse or mental health problem. The Project BEFORE service strategy combined a home visiting/case management strategy with individualized supports to families, such as strengthening a family's informal support network, connecting a mother with a 12-step program, and other community resources. Each family designated key members of its case management team, which typically included the parent(s), the home visitor, an early childhood specialist, and one or two others (such as a supportive neighbor, or a mental health or vocational counselor). Training for the staff was built on the Healthy Families America home visiting curriculum supplemented by mental health/substance abuse skills and strategies. Many of the staff who worked directly with families were themselves in recovery, which proved to be a major asset.

An evaluation of the first 205 families served found improved utilization of both physical and behavioral health services for the mothers and their children, significant reduction in changeable risk factors (e.g., decreases in exposure to violence, substance use, child abuse, and family arrests), and increases in the numbers of women working or in treatment, even though this program preceded TANF and there were no explicit work-related goals. (At intake, 17 percent of the women were working or going to school; after six months, 67 percent were working and 19 percent were going to school.)[45]

The fact that a program with explicit child development and family support goals but with no explicit work-related goals achieved the results promoted through welfare reform is significant. It suggests that for adults facing barriers to both parenting and employment, wanting to help their children can be powerful motivation. At the same time, the researchers confirm a theme found throughout this issue brief. Even as the families sought to address their special challenges, they continued to confront the basic pressures that all low-income families face—access to housing, adequate income, health services, transportation, and child care.[46]

Increased attention to the needs of the children of women in residential substance abuse treatment and in shelters for homeless or battered women and children is also in evidence.[47] Two such programs are highlighted below.

Rainbow House. Based in Chicago, Rainbow House is a shelter-based therapeutic program that provides a nurturing setting for adults and care and education for child witnesses to domestic and community violence. It serves primarily inner city children and families, including adult women and abused teens who are pregnant or parenting, providing them with a place to stay for up to one year. Rainbow House offers counseling and substance abuse services to the women and has recently begun a new partnership with the TANF program. There is a strong commitment to help mothers relate in new ways to their young children. For preschool-aged children, the strategy is based on the Head Start model coupled with the Choosing Non-violence curriculum that Rainbow House developed in conjunction with the Chicago Department of Human Services Children's Division.[48] For infants and toddlers, the program has developed what it calls Educational Advocacy Services, which provide a safe, stimulating environment where mothers can play and explore with their babies, always with a counselor available to model behavior and help as needed.

Exodus. In Compton, California, Exodus combines safe housing with substance abuse treatment for pregnant women or women with infants who have a long history of substance abuse and are at risk of homelessness. Mothers may also have older children with them. Staff include a substance abuse specialist, a clinical psychologist, a child psychologist, and staff experienced in dealing with sexual abuse. Eighty percent of the women report having been abused. Every family is assigned a counselor, a case manager, and a child development specialist. Young children attend a child development program or a therapeutic center. (For older children, there is an after-school program called Heroes and Sheroes.) Parents participate in a family council, and their advice has led to the development of support groups to deal with grief and loss as well as other issues. Families stay between ten months and two years. Exodus offers families lifetime aftercare services and is part

of a comprehensive, community-based set of programs for families affected by substance abuse in south central Los Angeles.[49]

These programs suggest an encouraging awareness that explicit strategies for young children (e.g., providing on-site, enriched, therapeutic child care, access to mental health and developmental services, and connections to other early childhood programs) can be integrated into intensive residential programs for their mothers. They also reinforce the message from nonresidential programs—that both the parents and their young children need help. But these programs are exceptions. Indeed, recently compiled data reveals that a 1990 survey found fewer family support services associated with substance abuse treatment for women than were available a decade earlier.[50]

Potential Opportunities to Use Welfare Reform as a Point of Entry

Providing intensive interventions to the most vulnerable young children and families can help meet the goals of welfare reform, and is good for the immediate well-being of the children and their school readiness, as well as their long-term productivity as workers and citizens. Four potential strategies using welfare reform as the entry points are highlighted here, although examples could not be found for all of them.

STRATEGY: Connect "child-only" cases with appropriate prevention, treatment, and support services.

Not all young children whose parents are affected by substance abuse, serious mental health issues, and domestic violence are living with their parents. Some have been removed and are in foster care placements, either with nonrelatives or relatives. So called child-only cases are those in which children are being raised by relatives, who, in return, get a small TANF grant to help pay for the children's basic needs. Many of these young children, regardless of who is caring for them, are left with the legacy of neglect or abuse by their parents. For this group of young children and their caregivers, the policy and practice challenge is twofold: (1) to provide support to their primary caregivers and (2) to ensure that these young children have access to the health and developmental supports they need to mitigate the risk factors to which they have already been exposed.[51]

Reports from the field suggest that frequently neither the relative caregivers nor, if the children are in foster care, their caseworkers are aware of how to obtain early intervention services, particularly for children experiencing developmental delays, through the federal Part C program.[52] Nor is there systematic evidence that special efforts are made to enroll these children in enriched childhood development programs.

STRATEGY: Address the needs of both custodial and noncustodial fathers affected by substance abuse, violence, and mental health issues, as well as mothers.

Attention to the importance of fathers, particularly noncustodial fathers, with respect to young children is growing. Many of these fathers are struggling in low-wage jobs, some are jobless, and some are in jail. Evidence suggests that these fathers, including those who are abusing substances,[53] have more contact with their children than the "noncustodial" label implies, especially when their children are young. (Less visible are the challenges that single-parent custodial fathers face. Single fathers now represent 16 percent of all single custodial parents.[54])

Under welfare reform, states have new opportunities to fund programs that address the needs of these high-risk fathers.[55] NCCP's recent report on state policies to promote responsible fatherhood describes three examples.[56] In Baltimore, through Healthy Start, a fathers' group has developed a powerful peer support network that includes efforts to address paternal nurturing and economic responsibility. Virtually all of the fathers are affected by the high-risk factors targeted in this issue brief. In Florida, a nurturing curriculum is offered to incarcerated fathers who are in prison because of violence, substance abuse, or other criminal activities. Results have been positive in one prison, and will be replicated elsewhere. In El Paso County, Colorado, the Center on Fathering is developing new strategies for low-income fathers affected by TANF, including support groups and individualized services. The fathers can also participate in ongoing activities and parent education offered by the Center, including access

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to a substance abuse counselor. These projects, and related efforts to help women resolve issues of gender, paternity establishment, and child support, represent an important pathway to address the treatment and parenting needs of fathers as well as mothers.

STRATEGY: *Use welfare-related dollars to promote integrated behavioral and child development activities for the most stressed young children and families.*

Under TANF regulations, states have unprecedented flexibility to use welfare dollars in nontraditional ways.[57] Moreover, most states have a healthy economy and surpluses as a result of the sharp decline in TANF caseloads. This means that states have the chance to link resources through TANF, early childhood programs, behavioral health services, and other related funding sources in new ways to jump-start the kind of system of supports that the most vulnerable young children and families need. The intricacies of using TANF in creative ways consistent with the law are complex, but there are many resources to help strategize and define new funding mechanisms. (See Appendix B for a selected listing of these resources.)

STRATEGY: *Bring TANF, early childhood, substance abuse, mental health, and domestic violence staff together.*

Those implementing welfare reform, developing self-sufficiency plans, and carrying out sanction policies are key to setting up the context that can help or hurt families and children. In an earlier report,[58] NCCP found relatively few formal partnerships between TANF staff and the early childhood community, although informal contacts were growing. There is evidence that some TANF offices are adding staff or consultants with expertise in substance abuse or domestic violence.[59] However, although it may exist, there are no reports of a welfare office staffed with, or with ready access to, specialists in child development, child mental health, or early intervention that are linked to substance abuse, mental health, and domestic violence specialists.[60] Yet the potential pay off of forging these connections both for the success of welfare reform and of achieving school readiness goals is great.

Putting the Examples in Perspective

Taken together, these examples highlight four key themes about helping families who have young children and face substance abuse, domestic violence, or mental health problems.

- ***The emerging body of practice knowledge represents a rich array of service delivery wisdom, although this knowledge has not yet been adequately tested through research and replication.*** (See box on page 13.)
- ***Building blocks and entry points for a support system for this population of young children and families are found in all localities.*** Every community has some kind of a network of early childhood services, some kind of access to a network of behavioral services (including mental health and substance abuse agencies, domestic violence agencies, and homeless shelters), and agencies charged with implementing welfare reform. What is needed is strategic planning and leadership to promote and sustain the connections—across federal programs (e.g., TANF and Part C) and among early childhood planning groups, welfare agencies, and those serving the most challenged adults.
- ***The policy and funding challenges cannot be minimized.*** Funding is a huge issue, particularly for children whose behaviors do not reach diagnosable thresholds. Similarly, despite the overwhelming evidence that adult risk factors do not exist in isolation, barriers to integrating federal substance abuse, mental health, and domestic violence dollars remain. Moreover, the lack of any systematic focus in the Children's Mental Health Services grant on high-risk young children is a limiting factor. Yet the examples cited above illustrate that funding can be found using blended funding streams, quality child care funds, and other mechanisms, such as targeting TANF dollars for specialized programs. With strong leadership, the needed mix of services can be developed, particularly if supported by new partnerships and coalitions.
- ***Additional service-related research is crucial.*** Although there are data supporting both specific intervention strategies and, increasingly, the use of

Emerging Practice Wisdom

- Helping their children can be a motivating goal for parents affected by substance abuse, domestic violence, and depression—for fathers as well as mothers.
- Interventions to repair damaged parent-child relationships and to help parents learn new parenting ways are crucial. Treatment for substance abuse, domestic violence, and mental health problems alone is not enough.
- Many young children in families affected by substance abuse, domestic violence, and parental mental illness have experienced some form of trauma and need enriched child development services that focus on enhancing their ability to form relationships. Some also need more formal interventions.
- Integrated service teams should include a child developmentalist who is able to identify, assess, and develop interventions related to developmental delays, emotional difficulties, and exposure to trauma. Children's developmental status should be addressed periodically, either informally (through observation) or by more formal means, such as referral to early intervention teams or preschool special educational services.
- Early childhood development programs (such as Early Head Start, Head Start, home visiting programs and other comprehensive programs) can be powerful allies in helping to promote the well-being of young children in vulnerable families in partnership with those working with the parents and with welfare agencies.
- Service delivery strategies for the entire family need to be intensive enough, long-lasting enough, clinically sophisticated enough, and practical enough to make a difference.
- A mix of formal and informal supports and concrete and therapeutic help seems to work best to address the basic as well as specialized needs of high-risk families. Exposure to those who are in successful recovery as parent aides or case managers seems especially helpful.
- Access to flexible dollars is key, since family needs vary.
- Direct service providers need to understand the general and jurisdictional-specific requirements of welfare reform. Welfare workers and administrators need to understand the special needs of these families. Both adult service providers and welfare workers need to understand why attention to the developmental and emotional status of young children should be part of all self-sufficiency plans.
- Building community-based service systems responsive to this population means building new partnerships, exploring different system and discipline expectations around treatment approaches and priorities, carrying out strategic assessment, planning, and cross-agency training, and using blended funding.

well-trained caregivers as predictors of better school performance for the general population of young children in low-income families,[61] research on the cost and impact of prevention and early interventions on behalf of the most vulnerable young children lags far behind the problem. Thus, although some beginning efforts are emerging to assess the impact of different clusters of services and supports, much more is needed.

Making Welfare Reform Work for the Most Vulnerable Adults and Their Young Children: Action Steps

Below are suggestions for steps states, communities, foundations, and other private-sector groups, as well as federal agencies and Congress might take to ensure that as their families work to meet the goals of TANF, the most vulnerable young children develop in ways that will enable them to enter school ready to succeed.

Toward an Enhanced State and Local Role

Strengthen the capacity within the early childhood community (including Head Start, Early Head Start, child care, preschool, home visiting programs, resource and referral agencies, and family resource programs) to serve the most vulnerable young children and their families in the context of welfare reform.

Use state, community, and private leadership and resources to:

- Provide challenge grants to promote community-based partnerships between the early childhood community and those involved with domestic violence, substance abuse, and mental health services for adults, as well as those implementing welfare reform.
- Develop funding streams, such as blended funds and challenge grants, to support training and consultation strategies directed toward the early childhood community to better serve the most vulnerable children and families.

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"Integrated services for high-risk young children and families are on the map, but not on the interstate ... welfare reform effort is an opportunity to address issues that have been with us for a long time. They are not new issues. What is new is that we have new program and policy flexibility to solve them."

A participant at the NCCP meeting, Promoting Child and Family Resilience in the Context of Welfare Reform, Washington, D.C., October 1998

- Use early childhood programs as an entry point to ensure that young vulnerable children and their families have easy access to all the federal programs to which they are entitled, especially health care through Medicaid and the State Child Health Insurance Program (CHIP), and early intervention services through Part C.

Strengthen the network of adult-focused substance abuse, mental health, and domestic violence services to better meet the needs of the most vulnerable young children and their families in the context of welfare reform.

Use state, community, and private leadership and resources to:

- Assess the status of services for young children in existing residential, shelter, and community-based treatment programs for adults.
- Provide fiscal incentives to behavioral and shelter support staff to build in deliberate strategies to address parenting and child development issues.
- Promote formal and informal partnerships between staff in mental health, substance abuse, and domestic violence programs and the network of early childhood programs existing within the community (including early intervention teams, Early Start, Head Start, prekindergarten, child care, and home visiting programs).
- Use substance abuse, mental health, and domestic violence programs as an entry point for family services and to ensure that young vulnerable children and their families have easy access to all the federal programs to which they are entitled, especially health care through Medicaid and CHIP and early intervention services through Part C.
- Evaluate the impact of different strategies on achieving school readiness and other measures of young child well-being.

Use welfare reform as a catalyst to address the needs of hard-to-serve adults effected by TANF and their young children.

Use state, community, and private leadership and resources to:

- Promote the use of TANF and related welfare dollars (such as Welfare-to-Work, Maintenance-of-Effort, and child support enforcement funds) to support integrated behavioral services for vulnerable families and young children. Exploit the opportunities to pay attention to fathers in these families.
- Ensure that cross-agency welfare implementation planning for adults (both women and men) affected by substance abuse, domestic violence, and mental illness includes representatives from the children's community, particularly the early childhood community.
- Provide cross-training for all welfare staff on the impact of substance abuse, domestic violence, depression, and other mental health problems on parenting and the well-being of young children, as well as information about and access to local agencies.
- Ensure that screening protocols for those implementing welfare for hard-to-serve adults include attention to the developmental issues for children in the family as well as safety-related issues.
- See that, at least for this vulnerable population of high-risk adults, time spent enhancing parenting strategies through home visiting programs or participation in other intensive parenting skill-building efforts is acceptable as part of self-sufficiency contracts and can count in meeting work requirements.

Encourage state and community advocacy organizations and policy councils or other planning groups to promote specific attention to this vulnerable group of young children and families in the context of a broader young children's agenda.

- Promote new partnerships among children's groups (such as Kids Count, state multiissue advocacy organizations, and state Head Start associations) with state and local mental health associations, coalitions to prevent domestic violence, and parents' groups (such as the Federation of Families for Children's Mental Health).
- Work with state legislators to help them understand the potential cost savings of a "two-generation" approach to implementing welfare reform on behalf of families with young children affected by substance abuse, mental health issues, and domestic violence.[62]

Toward a More Effective Federal Role

However much states and communities can do, it is important to recognize that most of the existing initiatives described here have been seeded with not just demonstration and research dollars, but *federal* demonstration and research dollars. Moreover, the federal government provides significant, if categorical, funding to address the needs of high-risk adults,[63] as well as funds for programs for young children. To promote an agenda on behalf of the most vulnerable young children and families, federal officials, policymakers, and advocates might consider the following:

Encourage federal agencies and Congress to develop a strong policy and research agenda to promote cost-effective prevention and treatment for the most vulnerable young children and their families in the context of welfare reform.

Questions for States and Communities to Consider

Where Does Your State Stand?
Key State Policy Choices

- How does your state address domestic violence in the context of welfare reform? Substance abuse? Mental illness, especially depression? What efforts are made to address the needs of high-risk children, especially young children in families affected by welfare reform?
- How does your state define welfare-related work activities? (Are substance abuse and mental health treatment included? What about involvement in parent-child relationship programs?)
- Has your state created working task forces focused on vulnerable young children and families affected by TANF?
- Is your state using TANF funds to develop integrated behavioral health and early intervention services for the most vulnerable young children and families affected by welfare reform?
- Has your state allocated mental health dollars for consultation and early intervention to help early childhood and family support providers deal with the more intensive needs of the children and families they serve?
- Is your state using the special-needs child care category under the Child Care and Development Fund to see that high-risk children are in comprehensive child development programs?
- Do Medicaid and CHIP provide appropriate health and mental health services to young children affected by substance abuse, domestic violence, and mental illness?

Where Does Your Community Stand?
Key Practice Choices

- In your community, are there links between those implementing TANF, early care and education, and home visiting programs, and substance abuse, mental health, and domestic violence programs?
- In your community, have you held a meeting with families who are in recovery or in treatment and are affected by welfare reform to ensure their voices are heard? How many have been sanctioned? What has happened to these families?
- In your community, are there outreach strategies to identify where the most high-risk young children are and what kinds of supports are available to them and their families?
- In your community, are there strategies to help staff in early childhood and family support programs help the most vulnerable young children and families? Other nonparental primary caregivers?
- In your community, have there been cross-training efforts involving staff of TANF, early childhood, mental health, and substance abuse agencies. Have shelter and child welfare staff and others involved in promoting positive outcomes for high risk adults with young children been included?
- Does your welfare agency have a screening tool that includes a focus on children?
- Are there outcome data on how well young high-risk children do when they enter school? What would it take to gather such outcome data?

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The time is right. There is a compelling family and societal case for taking a two-generation approach to adults affected by substance abuse, domestic violence, or mental illness and their young children.

- Increase attention to the most vulnerable young children in the context of implementing and evaluating the first national education goal—every child shall enter school ready to learn.
- Synthesize and widely disseminate the service and outcome-related research knowledge base about families with young children affected by substance abuse, domestic violence, and serious mental health issues to welfare agencies, to the early childhood community, and to those involved in providing or planning behavioral services.
- Create legislative incentives to promote intensive prevention and integrated intervention strategies and research on behalf of the most vulnerable young children and families (as well as families with older children).
- Promote parity for behavioral health services at the same level as physical health services in federal legislation for both adults and children.

Summary and Conclusion

Adults and their children affected by substance abuse, domestic violence, and serious mental health issues are an especially vulnerable subpopulation of those affected by welfare changes. This report has highlighted the risks that young children in these families face—poor health, difficulty with relationships, insufficient learning and mastering of social competence tasks—and it has documented, based on research and demonstration efforts, emerging practice strategies to help the families in the context of welfare reform. It has also underscored how few policy incentives and stable funding streams there are for states, programs, and communities to develop integrated service delivery programs or community-based systems of services that address the needs of both the adults and their young children. But it also makes clear that there are many opportunities, through early childhood programs, behavioral health services, and welfare reform, at the state, community, and federal levels to address the needs of these young children and families more effectively, and probably more cost-efficiently, than is often done now.

The time is right. There is a compelling family and societal case for taking a two-generation approach to adults affected by substance abuse, domestic violence, or mental illness and their young children. The flexibility permitted by recent welfare changes, coupled with TANF surpluses in most states and growing state investments in school readiness activities, set the stage for new partnerships. Caseloads are down, and the states have made the basic decisions about implementing TANF for the broader population. Pioneering programs and, to a lesser extent, policies, particularly those related to welfare reform, point to emerging strategies to promote self-sufficiency in adults and resilience and age-appropriate development in their children. Welfare reform compels attention to the adults, public national educational goals compel attention to the children, and common sense and psychological knowledge compel attention to both.

Appendix A: The Starting Early Starting Smart Sites

Program Designs and Auspices

Integrated SESS Services in Health Care Settings

- In Albuquerque, New Mexico, the SELECTT (Starting Early to Link Enhanced Comprehensive Treatment Teams) program, under the auspices of the Department of Pediatrics at the University of New Mexico's Health Sciences Center, uses strength-based, solution-focused therapy to help stressed parents and other caregivers. (For example, the therapist might say: "Tell me how you are able to keep your cool with a two-year-old in the midst of all that." "Tell me how you stopped smoking marijuana.") The program works with many specialized units in the hospital.

Integrated SESS Services in Child Care and Head Start Settings

- In Clark County, Nevada, New Wish counselors are on-site at the Head Start programs, offering both formal and informal help and support to families and staff. Each of the target families has its own individualized support team drawn from the state's early childhood services agency. The family chooses its own case manager from the team.
- In Arkansas, working with Head Start programs, the SESS project serves a nine-county rural area. Families and children have access to a multidisciplinary team while attending Head Start for two years, and follow-up in kindergarten. Each Head Start program has its own regional steering committee that brings together the multiple service agencies that are involved.
- In San Francisco, SESS is in four preschools serving primarily Chinese children and families, many of whom are recent immigrants. A family advocate works closely with the families, supported by a multidisciplinary team that includes health, mental health, and substance abuse professionals as well as an early childhood development specialist.
- In Miami, the University of Florida School of Medicine is examining the impact of an integrated behavioral service team coupled with a structured parent-child intervention; and if necessary, this is supplemented by a weekly therapeutic group focused on infant care, delivered in a public health clinic.
- Project RISE (Raising Infants in Secure Environments) at Boston Medical Center assigns family advocates to parents and caregivers who are active or former users, or are at high risk of substance abuse or addiction or mental health problems. The goals are to build a relationship, assist the family in following up on referrals, and work closely with the backup teams of substance abuse, mental health, and child development specialists. Special efforts have been made to make the project responsive to TANF—for instance, by providing staff training in welfare reform, particularly in relation to sanctions and time limits, and in helping families access jobs.
- In Columbia, Missouri, through the University of Missouri, the Healthy Foundations for Families program provides integrated services at a university pediatric primary care clinic. There, a family support staff member, with access to backup professionals, works with families to identify and coordinate services and increase parental knowledge about child development. When outside referrals are necessary, wraparound funds are used to support child care and transportation.
- In Baltimore, working with Head Start Programs, The Johns Hopkins University School of Hygiene and Public Health has crafted a strategy that involves prevention for all children and families. Activities include staff development, parent training (using the Effective Black Parenting program), and family support groups (using the Families and Schools Together program). The most vulnerable children receive targeted services.
- In Montgomery County, Maryland, the Family Services Agency provides home-based interventions to Head Start families in coordination with on-site mental health consultants. This is supplemented by cross-staff training and a county SESS interagency consortium.

- In Chicago, a collaboration among the Women's Treatment Center, Ounce of Prevention, and Head Start offers families in the target Head Start program access to more intensive family services, as well as substance abuse prevention and mental health services.
- In the state of Washington, Native American Tulalip families living both on and off the reservation have access to multidisciplinary teams which provide education and treatment in the areas of mental health, substance abuse, and domestic violence. Violence prevention and substance abuse prevention curricula are presented through preschool programs along with reading and gymnastics.

Integrated SESS Services in a Child Welfare Setting

- In Chicago, the National Association for Families and Addiction Research and Education is studying the impact of providing a range of integrated behavioral health services to children and their foster parents, as well as biological parents once they are able to have unsupervised visits. Services include family stress evaluation, parenting skills, training and support, caretaker-child therapy, family therapy, support groups, case management, and parent-toddler play groups.

Evaluation

- A national evaluation is in progress.

Source: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). (October, 1998). *Starting Early Starting Smart: Early childhood collaboration*. Washington, DC: SAMHSA. For contact information, see Appendix C.

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Appendix B: Helpful National Organizations and Agencies*

Bazelon Center for Mental Health Law
1101 15th Street, NW, Suite 1212
Washington, DC 20005-5002
Phone: (202) 467-5730
Web site: www.bazelon.org
Of special relevance: Information on mental health issues

Center for Law and Social Policy
1616 P Street, Suite 150
Washington, DC 20036
Phone: (202) 328-5140
Web site: www.clasp.org
Of special relevance: Analysis of welfare-related issues

Center on Budget and Policy Priorities
820 First Street, NE, Suite 510
Washington, DC 20002
Phone: (202) 408-1080
Web site: www.cbpp.org
Of special relevance: Information on welfare-related issues

Children's Defense Fund
25 E Street, NW
Washington, DC 20001
Phone: (202) 628-8787
Web site: www.childrensdefense.org
Of special relevance: Information on child care, welfare, and child welfare issues

Child Trends, Inc.
4301 Connecticut Avenue, NW
Washington, DC 20008
Phone: (202) 362-5580
Web site: www.childtrends.org
Of special relevance: Analysis of research related to children and poverty

Child Welfare League of America
440 First Street, NW, Third Floor
Washington, DC 20001-2085
Phone: (202) 638-2952
Web site: www.cwla.org
Of special relevance: Publications dealing with substance abuse problems in the context of child welfare

Federation of Families for Children's Mental Health
1021 Prince Street
Alexandria, VA 22314-2971
Phone: (703) 684-7710
Web site: www.ffcmh.org
Of special relevance: Parent advocacy for children with emotional and behavioral challenges

*More details about publications from many of these organizations appear in the endnotes.

Legal Action Center
153 Waverly Place
New York, NY 10014
Phone: (212) 243-1313
and
236 Massachusetts Avenue, NE, Suite 505
Washington, DC 20002
Phone: (202) 544-5478
Web site: www.lac.org
Of special relevance: Information on issues related to substance abuse

National Center for Children in Poverty
Columbia University
154 Haven Avenue
New York, NY 10032
Phone: (212) 304-7100
Web site: www.nccp.org
Of special relevance: Information on policies and practices regarding young children and welfare reform and state policies for young children and families, and syntheses of empirical data on welfare-related studies at www.researchforum.org

National Head Start Association
1651 Prince Street
Alexandria, VA 22314
Phone: (703) 739-0875
Web site: www.nhsa.org
Of special relevance: Annual institute on mental health in Head Start programs

National Mental Health Association
1021 Prince Street
Alexandria, VA 22314
Phone: (703) 684-7722
Web site: www.nmha.org
Of special relevance: Child health outreach initiative and advocacy for children with behavioral challenges.

National Technical Assistance Center for Children's Mental Health
Georgetown University Child Development Center
3307 M Street, NW
Washington, DC 20007-3935
Phone: (202) 687-5000
Web site: www.georgetown.edu
Of special relevance: Technical assistance related to early childhood mental health

Taylor Institute
926 N. Wolcott
Chicago, IL 60622
Phone: (773) 342-0630
Web site: www.taylorinstitute.org
See also: The Project for Research on Welfare, Work, and Domestic Violence
Web site: www.ssw.umich.edu/trapped
Of special relevance: Information on domestic violence issues

The Better Homes Fund
181 Wells Avenue
Newton, MA 02459-3344
Phone: (617) 964-3834 or (800) 962-4676
Of special relevance: Information related to homeless young children and families

The Urban Institute
2100 M Street, NW
Washington, DC 20037
Phone: (202) 833-7200
Web site: www.urban.org
Of special relevance: Analysis of welfare-related issues

Welfare Information Network (WIN)
1000 Vermont Avenue, Suite 600
Washington, DC 20005
Phone: (202) 628-5790
Web site: www.welfareinfo.org
Of special relevance: Web site bibliographies and resources on hard-to-serve families and general welfare information

Zero to Three
734 15th Street, NW, Suite 1000
Washington, DC 20005
Phone: (202) 638-1144
Web site: www.zerotothree.org
Of special relevance: Publications that focus on the emotional well-being of infants and toddlers; also hosts a technical assistance center for Early Head Start

FEDERAL AGENCIES

Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
Center for Substance Abuse Prevention
Center for Substance Abuse Treatment
U.S. Department of Health and Human Services
5600 Fishers Lane
Rockville, MD 20857
Phone: (301) 443-0001
Web site: www.samhsa.gov

Administration for Children and Families
U.S. Department of Health and Human Services
330 C Street, SW, Suite 2018
Washington, DC 20201
Phone: (202) 205-8572
Web site: www.acf.dhhs.gov/news/welfare

National Institute on Early Childhood Development and Education
Office of Education Research and Improvement
U.S. Department of Education
555 New Jersey Avenue, NW
Washington, DC 20208
Phone: (202) 219-1935
Web site: www.ed.gov/office/OERI/ECI

Appendix C: Contact Information

California Safe and Healthy Families (Cal-SAHF)
Contact: Terry Eisenberg Carrilio, Ph.D.
Address: San Diego State University, School of Social Work
College of Health and Human Services
5500 Campanile Drive, Hepner Hall 149
San Diego, CA 92182
Phone: (619) 594-8610

Children's Upstream Project (CUPS)
Contact: Charles Biss
Address: Mental Health Division
103 South Main Street, Weeks Building
Waterbury, VT 05671
Phone: (802) 241-2650

Day Care Plus
Contact: Ann Bowdish, Program Director
Address: Positive Education Program
3100 Euclid Avenue
Cleveland, OH 44105
Phone: (216) 361-4400, ext. 20 or (216) 361-7760, ext. 120

Exodus
Contact: Kathryn Icenhower, Director of Administration
Address: 1500 Kay Street
Compton, CA 90220
Phone: (310) 668-8311
Parent agency: SHIELDS for Families, Inc.

Project BEFORE (Bridging Empowers Families to Overcome Risks and Excel)
Contact: James Rast, Ph.D.
Address: Vroom Associates
(Catalysts for Quality Community Life)
1625 Grand Avenue
Parsons, KS 67357
Phone: (316) 421-3736

Project Relationship
Contact: Virginia Reynolds, Program Director
Address: CEITAN/WestEd
Center for Early Intervention and Prevention
429 J Street
Sacramento, CA 95814
Phone: (916) 492-9999

Rainbow House
Contact: Deidre Cutliffe, Executive Director
Address: 20 East Jackson, Suite 1550
Chicago, IL 60604
Phone: (312) 935-3430

Starting Early Starting Smart (SESS)
Contact: Sue Martone
Address: SAMHSA, Office on Early Childhood
U.S. Department of Health and Human Services
5600 Fishers Lane, Room 950, Rockwall II
Rockville, MD 20857
Phone: (301) 443-7762

Endnotes

1. Cash assistance caseloads dropped 40 percent between August 1996, when the federal PRWORA was passed, and March 1999 (see http://www.acf.dhhs.gov/news/stats/aug-sept.htm). A rapidly expanding economy and expansion of the federal EITC also have contributed to the decline in welfare caseloads.

2. For an overview, see: DeParle, J. (1999). As benefits expire, the experts worry. *The New York Times*, Oct 10, pp. A1, A22, and Minnesota Family Investment Program. (1995). *Survey of participant barriers to employment*. St. Paul, MN: Minnesota Department of Human Services.

3. In this issue brief, substance abuse refers to the use of alcohol, drugs, or other substances. The Division of Public Education and Dissemination, Center for Substance Abuse Prevention, of the U.S. Department of Health and Human Services recommends using the terms "alcohol, tobacco, and other drug [ATOD] use" or "abuse" when referring to "substance abuse" to emphasize alcohol's role in this problem and encourages more specific indication of the substances being used.

For descriptions of documents that can be used as resources to prevent substance abuse, see: Oshinsky, C. J.; Goodman, B.; with Woods, T. & Rosensweig, M. A. (1996). *Building bright futures: An annotated bibliography on substance abuse prevention for families with young children*. New York, NY: Free to Grow: Head Start Partnerships to Promote Substance-Free Communities, National Program Office, Columbia University School of Public Health and National Center for Children in Poverty, Columbia University School of Public Health.

4. This brief does not consider adults with serious physical disabilities or those who care for dependents with serious physical or emotional disabilities. The issue brief also does not focus explicitly on young children in the child welfare system, although some proportion of the children and families described here have been, are, or may be involved with child welfare. It does, however, recognize that many of the strategies that child welfare agencies are developing to help these families, particularly those affected by substance abuse, apply to the population not yet so involved.

For examples, see: Sweeney, E.; Schott, L.; Lazere, E.; Fremstad, S.; Goldberg, H.; Guyer, J.; Super, D.; & Johnson, C. (2000). *Windows of opportunity: Strategies to support families receiving welfare and other low-income families in the next stage of welfare reform*. Washington, DC: Center on Budget and Policy Priorities; Young, N. K. & Gardner, S. (1998) Children at the crossroads. *Public Welfare*, 56(1), pp. 3–10, 40–42; Young, N. K.; Gardner, S.; & Dennis, K. (1998). *Responding to alcohol and other drug problems in child welfare: Weaving together practice and policy*. Washington, DC: Child Welfare League of America (Electronic slide show version at www.cffutures.com/PPT/CWLA/); U.S. Department of Health and Human Services. (1999). *Blending perspectives and building common ground*. A report to Congress on substance abuse and child protection. (Copies available from the National Clearinghouse on Child Abuse and Neglect Information or www.acf.dhhs.gov/programs/cb/.) Fenichel, E. (Ed.). (1999). Child welfare and the under threes. *Bulletin of Zero to Three: National Center for Infants, Toddlers and Families*, 19(3), pp. 1–50. The entire issue focuses on young children in the child welfare system.

5. For a discussion of the psychological dimensions of the concept of resilience and its current research status see: Luthar, S. S.;

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Cicchetti, D.; & Becker, B. (In press). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development*, 71(3).

6. PRWORA sets forth strict work-related requirements (in half the states, mothers with infants must meet work requirements within the first three to six months of the infant's life), and has a five-year life time limit, although states can set shorter limits. Sanction policies for families that fail to meet work requirements are set by the state, and in some cases, by counties or other local jurisdictions. The choices made vary enormously from jurisdiction to jurisdiction, from a full-family sanction to the mobilization of a special team and/or review process as time limits approach.

7. If states formally adopt the Family Violence Option, they may screen and identify individuals/women for domestic violence, refer them for counseling and supportive services, and under specified circumstances, grant waivers from meeting requirements if doing so would jeopardize their safety. See: Rapael, J. & Haennicke, S. (1998). *The Family Violence Option: An early assessment*. Chicago, IL: The Taylor Institute. (Electronic version at www.ssw.umich.edu/trapped/pubs_marti.pdf)

With respect to drug abuse, unless the state opts out by enacting a law, an individual convicted of a drug use, possession or a distribution felony after August 22, 1996 is ineligible to receive TANF or food stamp assistance for life.

8. For a discussion of the mental health issues in relation to welfare reform see: Woolverton, M.; Wischmann, A.; McCarthy, J.; & Schulzinger, R. (1998). *Welfare reform: Issues and implications for children and families who need mental health or substance abuse services*. Washington, DC: Georgetown University Child Development Center. Distributed by the National Technical Assistance Center for Children's Mental Health.

9. *Goals 2000: Educate American Act*, P.L. 103-227, enacted March, 1994. The concept of school readiness addressed in this goal is broad, including attention to the emotional, cognitive, physical, and social aspects of child development.

10. U.S. Department of Health and Human Services, Administration of Children and Families, Office of Planning, Research and Evaluation. (1999). *Temporary Assistance for Needy Families (TANF) program: Second annual report to Congress, August, 1999*. Washington, DC: U.S. Department of Health and Human Services.

11. Center on Addiction and Substance Abuse and American Public Human Services Association. (1999). *Building bridges: States respond to substance abuse and welfare reform*. New York, NY: Columbia University, Center on Addiction and Substance Abuse. (Electronic version at www. aphsa.org) See also Raphael & Haennicke in endnote 7.

12. U.S. General Accounting Office. (1998). *Domestic violence: Prevalence and implications for employment among welfare recipients* (GAO/HEHS-99-12). Washington, DC: U.S. General Accounting Office Life time experiences reflected similar patterns: the national study found overall one in four women had been victims at some point in their lives, the state study found 65 percent of the AFDC recipients had been victims.

13. See: Urban Institute. (1999). *Snapshots of America's families*. Washington, DC: The Urban Institute.

14. See, for example, Downey, G. & Coyne, J. C. (1990). Children of depressed parents: An integrative review. *Psychological Bulletin*, 108, pp. 50–76.

15. Moore, K. A.; Zaslow, M. J.; Coiro, J. J.; Miller, S.; & Magenheim, E. B. (1996). *The JOBS Evaluation: How well are they faring: AFDC families with preschool-aged children in Atlanta at the outset of the JOBS Evaluation*. Washington, DC: Child Trends.

16. See, for example U.S. Department of Health and Human Services. (1997). *Substance use among women in the United States*. Rockville, MD: U.S. Substance Abuse and Mental Health Services Administration; Woolis, D. D. (1998). Family works: Substance abuse treatment and welfare reform. *Public Welfare*, 56(1), pp. 24–31; Jillson, I. A. (1998). *SAMHSA's Integrated Children and Family Initiative: Responding to an unmet need*. (Draft report). Bethesda, MD: Policy Research, Inc. and Groves, B.; Bassuk, E.; Lurie-Hurvitz, E.; & Valloton, C. (Eds). (1998). Home is a base for living. *Bulletin of Zero to Three: National Center for Infants, Toddlers and Families*, 19(1), pp. 1–5; and Danziger, S.; Corcoran, M.; Danziger, S.; Heflin, C.; Kalil, A.; Levine, J.; Rosen, D.; Seefeldt, K.; Siefert, K.; & Tolman, R. (In press). Barriers to the employment of welfare recipients. In R. Cherry & W. M. Rodgers, (Eds.). *Prosperity for all? The economic boom and African Americans*. New York, NY: Russell Sage Foundation. (Electronic version at www.ssw.umich.edu/poverty/pubs.html)

17. Zeanah, C., Jr. (Ed.). (1993). *Handbook of infant mental health*. New York, NY: The Guilford Press and Aber, J. L.; Jones, S.; & Cohen, J. (1999). The impact of poverty on the mental health and development of very young children in Zeanah, C. (Ed). *Handbook of infant mental health, 2nd ed.* New York, NY: The Guildford Press.

18. See NICHD Early Child Care Research Network. (1999). Chronicity of maternal depressive symptoms, maternal sensitivity, and child functioning at 36 months. *Developmental Psychology*, 35(5), pp. 1297-1310. See also National Institute of Child Health and Human Development. (1999). *Maternal depression linked with social and language development, school readiness: maternal sensitivity helps these children fare better* (NIH News Alert). (Electronic version at: www.nichd.nih.gov/new/releases/depression.htm)

19. Knitzer, J. (2000). Early childhood mental health services through a policy and systems development perspective. In J. P. Shonkoff & S. J. Meisels, (Eds.). *Handbook of early childhood intervention, 2nd ed.* New York, NY: Cambridge University Press; and Yoshikawa, H. & Knitzer, J. (1997). *Lessons from the field: Head Start mental health strategies to meet changing needs*. New York, NY: National Center for Children in Poverty, Joseph L. Mailman School of Public Health, Columbia University.

20. See Zeneah in endnote 22, and Zero to Three (1994). *Diagnostic classification of mental health and developmental disorders of infancy and early childhood*. Arlington, VA: Zero to Three/National Center for Clinical Infant Programs.

21. See Jillson in endnote 16.

22. See endnote 19.

23. See Luthar in endnote 5. At the same time, it is also important to underscore that these are generalities; individual patterns vary greatly, access to "protective factors," such as a caring grandparent can make a huge difference, and there also seem to be important, but relatively little understood cultural and ethnic factors at play. For example, a recent study of children of teenage mothers found that children showed increased disruptive behaviors between ages two and six when their mothers were anxious and depressed, and used harsh discipline. This effect was not as strong for African-American mothers. See Spiekers, S.; Larson, N. C.; Lewis, S. M.; Keller, T. E.; & Gilchrist, L. (1999). Developmental trajectories of disruptive behavior problems in preschool children of adolescent

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mothers. *Child Development*, 70 (2), pp. 443–458.

24. See, for example, Gomby, D. S. & Larner, M. B.; Stevenson, C.S.; Lewit, E.M.; & Behrman, R. E. (Eds). (1995). Long-term outcomes of early childhood programs: Analysis and recommendations. *The Future of Children*, 5(3), pp. 6–24; Luthar, S. S. (1999). *Poverty and children's adjustment*. Thousand Oaks, CA: Sage.

25. Duncan, G. J.; Brooks-Gunn, J.; & Klebanov, P. K. (1994). Economic deprivation and early childhood development. *Child Development*, 65(2), pp. 296–318.

26. Kaplan-Sanoff, M.; Parker, S.; & Zuckerman, B. (1991). Poverty and early childhood development: What do we know, what should we do? *Infants and Young Children*, 4(1), pp. 68–76.

27. See, for example, Downey, G. & Coyne, J. C. (1990). Children of depressed parents: An integrative review. *Psychological Bulletin*, 108, pp. 50–76; Osofsky, J. D. (1995). The effects of exposure to violence on young children. *American Psychologist*, 50, pp. 782–788; Karr-Morse, R. & Wiley, M. S. (1997). *Ghosts from the nursery: Tracing the roots of violence*. New York, NY: Atlantic Monthly Press; Kaufman, R. K. & Dodge, J. M. (1997) *Prevention and early interventions for young children at risk for mental health substance abuse problems and their families: A background paper*. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

28. See, for example, Shore, R. (1996). *Rethinking the brain: New insights into early development*. New York, NY: Families and Work Institute.

29. Known as wraparound services or supports, they include involving other family members in the support and recovery process and other indirect supports or services to help the primary individual or family with their problems. Wraparound services when used in a mental health context refer to a flexible set of individualized services designed to meet the particular needs of a family, rather than a cookie-cutter approach to mental health treatment. The same term is used in the early childhood field to refer to efforts to link preschool and Head Start with full day child-care

30. Knitzer, J. & Cauthen, N. K. (1999). *Enhancing the well-being of young children and families in the context of welfare reform: Lessons from early childhood, TANF, and family support programs*. Washington, DC: U.S. Department of Health and Human Services, and Cauthen, N. K. & Knitzer, J. (1999). *Beyond work: Strategies to promote the well-being of children and families in the context of welfare reform* (Children and Welfare Reform Issue Brief No. 6). New York, NY: National Center for Children in Poverty, Joseph L. Mailman School of Public Health, Columbia University.

31. See Yoshikawa & Knitzer in endnote 19.

32. See, for example, the 1996, 1998 and the forthcoming 2000 edition of NCCP's series, *Map and Track: State Initiatives for Young Children and Families*.

33. Although Head Start has long had a very powerful parent involvement program, this group of families are difficult to engage. Typical strategies often do not work, and even approaches that are effective for most families, such as the Partners Project, a facilitated peer parent education support strategy is not successful. See Yoshikawa & Knitzer in endnote 19.

34. For instance it was named in both the 1996 and 1998 editions of *Map and track: State initiatives for young children and families* as one of the eight states providing sustained leadership on early childhood issues. The state has regional networks of Healthy Babies home visiting programs, Parent-Child Centers, a deliberate strategy to link welfare reform implementation, (including outreach to non-custodial and custodial fathers), with improving outcomes for young children, and an outcome driven set of regional indicators used for planning.

35. Santarcangelo, S. & Mikkelsen, K. (1997). *Prevention and early intervention: Necessary next steps, report of the Task Force on Mental Health Needs of Young Children and Their Families*. Montpelier, VT: Vermont State Department of Education and Agency of Human Services.

36. The initial work was funded by the U.S. Department of Special Education, Office of Special Education and Rehabilitative Services, Early Education Program for Children with Disabilities (Grant #H024B10028: Delivering Special Education Services in Urban, Culturally Diverse Child Care Centers). See also: Paulsen, M. & Cole, C. (1996). *Project Relationship: Creating and sustaining a nurturing community*. A manual and a video illustrating a relationship-based problem-solving framework for improving staff communication, enhancing child success, and enriching program practices in early childhood settings. Los Angeles, CA: Los Angeles Unified School District Division of Special Education Infant and Preschool Programs.

37. For other examples, see: Donahue, P.; Falk, B.; & Gersony-Provet, A. (2000). *Mental health consultation in early childhood*. Baltimore, MD: Paul H. Brookes.

38. For a fuller description, see: Cauthen, N. K. & Knitzer, J. (1999). *Beyond work: Strategies to promote the well-being of children and families in the context of welfare reform* (Children and Welfare Reform Issue Brief No. 6). New York, NY: National Center for Children in Poverty, Joseph L. Mailman School of Public Health, Columbia University.

39. Collins, A. & Carlson, B. (1998). *Child care by kith and kin: Supporting family, friends and neighbors caring for children* (Children and Welfare Reform Issue Brief No. 5). New York, NY: National Center for Children in Poverty, Joseph L. Mailman School of Public Health of Columbia University.

40. For example, a study of Hawaii's Healthy Family programs found that one-third of the families had experienced too much grief, too much loss and too much domestic violence to benefit from the basic program. See Wallach, V. A. & Lister, L. (1995). Stages in the delivery of home-based services to parents at risk of child abuse: A Healthy Start experience. *Scholarly Inquiry for Nursing Practice: An International Journal*, 9(2), pp. 159–173. See also Yoshikawa & Knitzer in endnote 19.

41. Although there has been a rapid expansion of new home visiting programs, evaluation data on impacts are equivocal. Interestingly, there has been little analysis of the level of risk in the families matched against the program design and particularly the staffing patterns. See Gomby, D. S.; Culross, P. L.; & Behrman, R. E. (1999). Home visiting: Recent program evaluations—analysis and recommendations. *The Future of Children*, 9(1) pp. 4–26.

42. Carrilio, T. E. (1998). *California Safe and Healthy Families: A family support home visiting mode, executive summary*. San Diego, CA: School of Social Work Policy Institute, San Diego State University.

43. It is encouraging that there are beginning to be some research-based efforts to explore parenting strategies in the context of treatment, although not yet specifically for families with young children. In particular, the research-based work of Dr. Suniya Luthar and her colleagues tells a powerful story. Working with parents in a methadone maintenance clinic, Dr. Luthar helped them through a

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structured series of group sessions to address parenting issues and grief that they had otherwise no opportunity to explore. See: Luthar, S. & Suchman, N. E. (In press). Relational psychotherapy mothers' group: A developmentally informed intervention for at-risk mothers. *Development and Psychopathology*; Luthar, S. S. & Suchman, N. E. (1999). Developmentally informed parenting interventions: The relational psychotherapy mothers' group. In D. Cicchetti & S. L. Toth. (Eds.). *Developmental approaches to prevention and intervention*. (Rochester Symposium on Developmental Psychopathology. Vol. 9). Rochester, NY: University of Rochester Press. Dr. Luthar's colleague, Dr. Thomas McMahon is now trying to adapt the strategy for substance-abusing fathers. See also McMahon, T. J. & Luthar, S. (1998). Bridging the gap for children as their parents enter substance abuse treatment. In R. L. Hampton; V. Senatore; & T. P Gullota (Eds.), *Substance abuse, family violence and child welfare: Bridging perspectives*. Thousand Oaks, CA: Sage; and Van Bremen, J. R. & Chasnoff, I. J. (1994). Policy issues for integrating parenting interventions and addiction treatment for women. *Topics in Early Childhood Special Education*, 14(2), pp. 254–274.

44. This built upon a previous SAMHSA research and development program involving over 60 residential programs providing substance abuse treatment to parents and services to their infants.

45. Rast, J. (1997). *Lessons from the village (What I have learned from the community about early intervention and prevention)*. Parsons, KS: KanFocus.

46. Shirk, M.; Bennett, N. G.; & Aber, J. L. (1999). *Lives on the line: American families and the struggle to make ends meet*. Boulder, CO: Westview Press.

47. See Allen, M. L. & Larson, J. (1998) *Healing the whole family*. Washington, DC: Children's Defense Fund. McHardy, L. W. & Hofford, M. (1998). *Family violence: Emerging programs for battered mothers and their children*. Reno, NV: National Council of Juvenile and Family Court Judges; and National Abandoned Infants Assistance Resource Center. (1997). *Integrating services and permanent housing for families affected by alcohol and other drugs. A guidebook and resource manual*. Berkeley, CA: School of Social Welfare, University of California.

48. See Parry, A.; Walker, M.; & Heim, C. (1990). *Choosing nonviolence: The Rainbow House handbook to a violence-free future for young children*. Chicago, IL: Rainbow House/Arco Iris.

49. See Allen & Larson in endnote 44 for fuller descriptions of Rainbow House and Exodus.

50. See U.S. Department of Health and Human Services, in endnote 4.

51. Berns, D. A. & Drake, B. J. (1999). Combining child welfare and welfare reform at a local level. *Policy and Practice of Public Human Services. The Journal of the American Public Human Services Association*, 57(1), pp. 26–34.

52. The Part C program of IDEA, the federal special education law, makes it possible for infants and toddlers experiencing developmental delays (as defined by the state), and in some states, experiencing conditions that place them at risk of experiencing delays, to access services such as physical therapy, occupational therapy, etc. See also Silver, J.; DiLorenzo, P.; Zukoski, M.; Ross, R. E.; Amster, B. J.; & Schelgel, D. (1999). Starting young: Improving the health and developmental outcomes of infants and toddlers in the child welfare system. *Child Welfare*, 78(1), pp. 148–165.

53. For example, Dr. Thomas McMahon at Yale University found that among a sample of 50 men in a methadone maintenance program, over half reported being present at the birth of their child, although contact was often interrupted by jail time. (Reported at NCCP meeting on October 29, 1998.)

54. For an example of how one shelter program in Maryland served a single custodial father whose addiction cost him his job and his home, but not yet his three children (two young and one adolescent) see Allen & Larson in endnote 47.

55. If states include fathers as members of the family, TANF dollars can be used even if the fathers are not in residence. States can also use Welfare-to-Work grants, as well as child support enforcement activities to promote fatherhood in the context of welfare implementation.

56. For more in-depth discussion of recent policy, research, and practice developments with respect to the state's role in promoting responsible fatherhood see: Bernard, S. & Knitzer, J. (1999). *Map and track: State initiatives to promote responsible fatherhood*. New York, NY: National Center for Children in Poverty, Joseph L. Mailman School of Public Health, Columbia University.

57. See U.S. Department of Health and Human Services, Administration for Children and Families. (1999). Temporary Assistance for Needy Families Final Rule. *Federal Register*, 64(69), pp. 17719–17768; U.S. Department of Health and Human Services, Administration for Children and Families. (1999). *Helping families achieve self-sufficiency: A guide on funding services for children and families through the TANF program*. Washington, DC: U.S. Department of Health and Human Services; and Greenberg, M. H. (1999). *Beyond welfare: New opportunities to use TANF to help low-income working families*. Washington, DC: Center for Law and Social Policy.

58. See endnote 30.

59. See Center on Addiction and Substance Abuse and American Public Human Services Association in endnote 11. Also see Raphael, J. E. & Haennicke, S. (1999). *Keeping women safe through the welfare-to-work journey: How are we doing? A report on the implementation of policies for battered women in State Temporary Assistance for Needy Families (TANF) programs, final report*. Chicago, IL: Taylor Institute. (Electronic version at www.ssw.umich.edu/trapped/pubs.html)

60. In Vermont, Reach-up workers (Vermont's case managers under TANF) are stationed in, and trained and hired by the staff of their Parent-Child network, as well as being trained by the state's welfare agency. See Knitzer & Cauthen in endnote 30.

61. See Gomby & Larner in endnote 17 and Peisner-Feinberg, E. S.; Burchinal, M. R.; Clifford, R. M.; Culkin, M. S.; Howes, C.; Kagan, S. L.; Yazejian, N.; Byler, P.; Rustici, J.; & Zelazo, J. (1999). *The children of the cost, quality and outcomes study go to school: Technical report*. Chapel Hill, NC: University of North Carolina, Frank Porter Graham Child Development Center.

62. Two-generation programs combine services for the healthy development of poor children with activities to help parents become economically self-sufficient. For examples of successful two generation programs, although without a special focus on the most high-risk families, see Smith, S. (Ed.). (1995). *Two-generation programs for families in poverty: A new intervention strategy*. Norwood, NJ: Ablex.

63. These funding streams include (but are not limited to): The Children's Mental Health Services Grant, the Substance Abuse Prevention and Treatment Block Grant; The Mental Health Block Grant, TANF, the Child Care and Development Fund, and the Family Violence Prevention and Services Program.

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